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ABSTRACT

This paper discusses the extent, distribution, and consequences of socially isolated mothers. First, the author considers what are likely to be the negative effects of isolation on both the emotional and physical health of mothers, and the resulting implications of these effects for the primary prevention of a wide range of emotional and physical problems. Next, arguing that we do not know enough about social isolation beyond its possible effects on health, the author reviews data which have a bearing on the prevalence and distribution of social isolation in the population and how it affects mothers and through them their children on a day-to-day basis. Finally, the author discusses the implications of these findings for intervention and briefly describes the efforts in one particular neighborhood to reduce the isolation of mothers at home with their preschool children. Data reflecting the extent, distribution, and other characteristics of isolated mothers are included in tabular form. (Author/MP)

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THE SOCIALLY ISOLATED MOTHER:

Distribution, Day to Day Effects and Implications for Intervention

by

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INTRODUCTION[1]

In this paper I discuss the social isolation of mothers. I start by considering what are likely to be its negative effects on their health, both emotional and physical, and the resulting implications for the primary prevention of a wide range of conditions. Then, arguing that we do not know enough about social isolation beyond its possible effects on health, I review data which have bearing on its prevalence and distribution in the population and on how it affects mothers and through them their children on a day to day basis. Then I discuss implications for intervening and describe briefly the efforts in one particular neighbourhood to reduce the isolation of mothers at home with their preschoolers.[2]

WHAT ARE THE CONSEQUENCES OF SOCIAL ISOLATION?

Evidence is accumulating from studies in Australia, Canada, England and the United States suggesting that there are more emotional and physical problems among people who lack social relationships to provide them with needed supports than there are among those who have such relationships. More specifically, the socially isolated

1) are more often experiencing non-psychotic psychological difficulties than those who have support (much work has focused on depression to date; 2,3,5,8,13,18,21,22),

2) are more likely to die from physical illnesses (4,20),

3) are more likely to be classified as physically impaired in a health survey (3),

4) report more physical symptoms in a response to unemployment (12) and possibly widowhood (23) and

5) are slower in recovering from road accidents (29) and possibly heart attacks (10).

Some have expressed concern that many of the studies cited are sufficiently weak methodologically that the confidence expressed in this connection between isolation and health by others (6,19) is not justified (21). However, data available in recent years from studies with improved methodology are consistent with the findings in earlier studies (8,18,21,29). So while caution is still required the assertion of a general connection seems reasonable and certainly warrants

fuller exploration.[3]

The specifics of how isolation affects health are not yet known. However, it seems plausible that it both directly and indirectly increases the level of stress individuals experience, thereby increasing their general susceptibility to dysfunction. To elaborate briefly, people's reliance and even dependence on relationships with others for self-definition and a sense of worth, which some see as particularly characteristic of North American cultures (11,24,25), mean that social isolation is likely to be a stressor, especially so if it is involuntary. Without these relationships, our sense of ourselves and our worth is threatened. In this way isolation can have a direct affect on stress. In addition, socially isolated people who experience stressful life events, like their child being sick or being short of money, face these events alone, lacking the advise, help and comfort that can be provided by others. It seems likely, therefore, that they will cope less well with such stressors. Isolation, to the extent that it reduces effective coping with these stressors, has an indirect effect on stress. Not surprisingly, there is evidence in the studies cited for both the direct effect and an indirect effect, through an interaction with the level of stress in a person's life. (The best examples are in the studies by House and Wells, 1978 and LaRocco et al, 1980 looking at the effects of occupational stress.)

It seems possible then that the socially isolated individual is more highly stressed and experiences a general susceptibility to dysfunction (28), which ends up being expressed in ways reflecting the individual's cultural background and physical and emotional disposition.

Should social isolation have a role in both physical and mental dysfunction, whether in these ways or others, it would be a very valuable focal point for prevention efforts. To reduce social isolation could reduce the prevalence (secondary prevention) and possibly the incidence (primary prevention) of a wide range of dysfunctions.[4]

Conceptually, this means focusing on one factor that may have a role in a large range of conditions rather than searching for numerous factors to affect one condition. This is a particularly important way to approach social problems.

Unlike in work with physical illness where a specific cause is sometimes found that enables prevention, as for example in the case of polio, such an approach has not proved fruitful with social dysfunctions. The search for the causes of delinquency, child abuse, depression and so on have not yielded highly effective prevention strategies. Though optimism seems justified in the case of some emotional dysfunctions it seems less justified in the area of behavioural problems. In this context, looking to reduce the incidence of conditions like social isolation that heighten vulnerability to numerous dysfunctions, including physical, emotional and behavioural dysfunctions, seems valuable. It may be an important cost-effective approach. It is also likely to be politically viable, but discussion of this is beyond the scope of this paper.[5]

HOW PREVALENT IS SOCIAL ISOLATION?

In setting priorities for spending money on prevention efforts it has been suggested that we focus on conditions that affect a large number of people (1,7). While usually it is being suggested that we focus on dysfunctions that affect a large number of people, the recommendation would seem to apply equally well to contributing factors. What about social isolation, is it prevalent enough to warrant investing time and money?

The data from five studies are reported in Table 1. They come from a suburban Australian community, urban communities in the United States, England and Canada and a mixed urban/suburban sample from a large metropolitan area in Canada.

The measures of isolation differ from study to study, making direct comparison inappropriate. Despite this, some general observations can be made on two measures, crisis help and marital status, that have been found to relate both to greater psychiatric symptomotology and to poorer physical health. Looking first at help available in a crisis, in the suburban Australian community described as a well-established, low mobility community by the researchers, the percentage of those lacking comfort in a crisis was 4.9% and those lacking material help in a crisis was 8.3%. In an urban section of Toronto, reputed for its solidarity, 19% of the respondents did not have emergency help available in their social networks.

Turning to marital status, Brown et al indicate that 38.3% of their sample of women from a working class district of London did not have a confiding relationship with a spouse. Removing those who are single, widowed and divorced and only looking at the married women, one in four, or 26.6% still report that they did not have a confiding relationship with their spouse. Lacking such a relationship was found to be strongly related to depression by Brown et al in their study. In the study done in Metropolitan Toronto by Michelson et al, 25.4% of the women raising children indicated they could not turn to a spouse with personal problems. Considering married women only this figure drops to 6.7%. 2.2% of the mothers have no one to turn to, neither a spouse nor someone outside the household.

Using the random sample in the Wellman study, it appears that some 16,000 adults in one of six municipalities in Toronto lacked help needed in an emergency and some 34,000 lacked help needed in dealing with day to day situations. Using the percentages to project the numbers reveals that the number of people whose health is at risk because they lack supportive relationships may be quite high. This is especially so considering that it is reasonable to assume, first, that severe isolates are not likely to be as willing to be interviewed as others and, therefore, are likely to be under-represented in the samples and, second, that once in an interview it is difficult to admit lack of support, especially within a marital relationship. The numbers are likely to be higher. Isolation is likely to be a prevalent risk factor. (The sample in the Michelson et al study was a stratified sample and could not be used to estimate the number of isolated people.)

While isolation may be prevalent, much more research is needed to provide a clearer picture of the situation. For example, it is important to determine how frequently these figures reflect a prolonged and presumably a more detrimental state and to determine if these are the best indicators of risk. Also since stressful life events compound the risk of being isolated, it is important to determine the extent to which these life events and isolation covary. And in order to intervene, it is necessary to know, first, how isolation is distributed, that is, whether certain identifiable groups are more isolated than others, and, second, how isolation affects a person on a day to day basis, that is, what its dynamics are, so that interventions can be designed that are sensitive to its effects and are, therefore, more likely to be successful.

The Michelson et al study done in Metropolitan Toronto has some data relevant to the last two points, regarding the distribution and day to day effects of isolation. These data are presented after a brief discussion of the isolation measure.

MEASURE OF SOCIAL ISOLATION

Mothers were asked about who outside the household they could turn to;

1) to do emergency babysitting for an hour or two,

2) to do emergency babysitting for a weekend,

3) to do an errand,

4) to advise them about a problem with one of their children, and

5) to talk with them about a personal problem.

They were also asked in 5 if they could turn to their spouse for most problems.

A continuum of isolation was created by assigning values to the different answers to the above five questions. A value of zero was given when a mother answered "no one" or "a professional". If one person was mentioned or the husband or children were mentioned, the answer was given a score of 1. If the answer was family, friends or neighbours, indicating more than one person, a score of 2 was given. And if a combination of two or more of family, friends, neighbours or professionals were given, a score of 3 was assigned. The result is a continuum that runs from zero to 15.

This continuum was then run against numerous other variables to determine whether the hypothesized relationships between isolation and demographic and behavioural variables existed and, if so, whether there were consistent cut-off points. The findings will be reported momentarily. In terms of cut-off points, there were several points at which there were consistent changes in the behaviours of mothers. The result is a four-point scale.

The extremely isolated (n = 13) are those who indicated that they could not turn to their spouse for most problems and that they had one person to

turn to for, at most, three of the five items. The isolated (n = 43) differ from the extremely isolated only in that they can turn to their husbands. They have a similarly low level of support outside the home. The moderately supported (n = 414) range from having someone to respond to four or five of the needs to having family, friends or neighbours who can help out on each of the items. The highly supported (n = 53) indicate a combination of family, friends, neighbours or professionals to at least four of the five items.

Data available from a time budget kept by the mothers for a 24-hour period give this indicator of isolation some cross-validation. The above measure of social isolation reflects primarily isolation from the help and comfort provided through social relationships that are important to coping. This can be distinguished from the social contact provided through socializing. While different, there is likely to be a relationship between the two. Those who have fewer people to socialize with are likely to have fewer people to turn to for help.

It turns out that mothers who fall into the two isolation categories do socialize significantly less often than women in the supported groups (Table 2; $\chi^2 = 9.69$, df = 2, $p < .01$).[5] Socializing includes general social activities, talking with friends or family on the phone, going to parties or going out to play cards, that is, the kinds of recreation that have socializing as a major element. Similarly, mothers who fall into the two isolation categories go on outings significantly less often than women who are moderately supported. In this case the women who are highly supported go on outings significantly more often than the others (Table 2; $\chi^2 = 10.76$, df = 2, $p < .01$), outings being things like going to a movie, sports event, a parade, theatre, etc. In addition, not only do isolated mothers go out less often, when they do go out they go alone more often and with friends less than the moderately supported and with friends and family less than the highly supported (Table 2 (who with socializing); $\chi^2 = 9.61$, df = 2, $p < .01$; Table 2 (who with outings); $\chi^2 = 10.28$, df = 2, $p < .01$).

These patterns hold primarily for mothers who are at home, who have neither full-time nor part-time paid employment. This is understandable in that working women have less free time. Therefore, there is a ceiling on how often they can go out and there is not as likely to be a difference between isolated and less

isolated women.

To summarize, isolated mothers, particularly isolated mothers at home, go out less and when they do go out they go out less often with family and friends. Highly supported women go out more often and when they do go out they go out more often with family and friends. These patterns suggest the indicator of social isolation has some validity in terms of the social activities reported in a time budget filled out by the mothers.

While this indicator of social isolation has proven useful, as can be seen in what follows, it is not readily apparent why the groups divide as they do. More work is planned to try to identify the significant aspects of isolation. The results reported here are based on this first attempt at defining social isolation and are best considered preliminary.[6]

HOW IS ISOLATION DISTRIBUTED IN THE POPULATION?

The data in Table 3 indicate that isolation is not evenly distributed but varies from one area of the city to another ($\chi^2 = 18.75$, df = 10, $p < .05$). The low is 7.7% in wealthy, well-established areas of the City of Toronto and the high 27.8% (column percentages) in poorer, more ethnically diversed areas. These "areas" are combinations of census tracts and while it would be more valuable to look closely at individual neighbourhoods or even census tracts it is not possible. Preliminary analyses of data from a reliability study of a measure of social support for another study (17) suggests that there are interviewer differences in the extent of support elicited. Since, in this study, one interviewer often did all the interviews in a census tract, it is necessary to examine variation by area of the city and not by census tract to lessen the likelihood that observed differences reflect interviewer differences instead of real differences.

Other studies suggest other factors, besides geographic area, that can be the basis of variation. Single women have been found to be more isolated than married women (13), lower SES women to be more isolated than higher SES women (3), and mothers of preschoolers to be more isolated than mothers with older families (4).

The data reported here confirm the previous finding about single women but no other. Single mothers are more isolated (Table 4; $\chi^2 = 10.29$, df = 1, $p < .01$). They are no more likely to lack support outside the home than married mothers. What they lack is the support of a spouse and therefore disporportionately fall into the extreme isolation group.

Isolation does not vary with income.[7] Mothers of preschoolers are significantly less isolated than mothers without preschoolers (Table 4; $\chi^2 = 6.82$, df = 2, $p < .05$). In this study it is having an adolescent that is associated with greater isolation (Table 4; $\chi^2 = 10.32$, df = 2, $p < .05$).[8]

Two other variables that could reasonably affect isolation, housing and work status, showed no relationship to this measure of isolation. More specifically, there are no significant differences in the level of isolation across five types of housing; single family homes, semi-detached homes, townhouses, four-floor or less apartment buildings and four-floor or more apartment buildings. And there are no differences in the level of isolation among mothers who have full-time paid employment outside the home, mothers who have part-time paid employment outside the home or mothers who are at home full-time.

There are several possible explanations for the differences in the findings in this study and others.

1. The measures of isolation differ from study to study (also SES).

2. Different groups are isolated in different cultures. The Metropolitan Toronto sample is a highly mixed ethnic sample and the isolation patterns may vary from culture to culture, providing a different overall pattern than in more homogeneous samples.

3. In general, isolation may not vary in simple ways and may therefore require a larger n to enable a closer look at how variables interact. For example, it may be that lower SES mothers with preschoolers who live in subsidized housing are more isolated than other mothers with preschoolers, but the n in the sample allows no such assessment. (This would be consistent with the finding in the study in the working class community in London.)

4. Isolation does not vary systematically with demographic variables but reflects, for example, a character trait which cuts across different group memberships.

These possibilities, especially the second and third, highlight the difficulty in studying a phenomenon that occurs with relatively low frequency in the population. Studies are needed which draw samples in ways more carefully attuned to the issues of isolation.[9] Given the numbers of those isolated and the extent to which they are at risk, such a study does seem warranted.

WHAT ARE THE DAY TO DAY EFFECTS OF ISOLATION?

It is important to understand how an isolated mother feels and behaves in order to design interventions to try to reach her. A variety of data are available from the time budget study. Earlier it was suggested that isolation causes stress. In the time budget study, the mothers were asked to assign a score, indicating whether they felt tense or relaxed (1 = very tense to 7 = very relaxed), to each of their entries in their time budget for the previous 24-hour period. An average was calculated for each mother. The mothers who fall into the two categories of isolation are more likely to experience tension as they go through their daily activities (Table 5; $\chi^2 = 15.24$, df = 2, $p < .01$). One in four has an average tension score falling into the tense range of the seven-point scale compared to one in ten of the non-isolated. This is strongest for women at home but also appears for women who have paid employment.

Why the tension? One possibility goes back to the earlier notion that an isolated mother, in having fewer people to help her, copes less well and experiences tension. In this case the coping is with day to day responsibilities and not crises. The idea is that she experiences stress in her daily round of activities because she has too much to do and lacks needed help.

There is some support for this interpretation in the finding that the isolated mother goes out less, mentioned earlier, and it is supported by other findings. The isolated mother has a tendency to perceive that she has much too much to do (Table 6; $\chi^2 = 17.87$, df = 6, $p < .05$) and she perceives less choice on the average about what she does (Table 6; $\chi^2 = 6.86$, df = 2, $p < .05$). She

spends less of her time in leisure activities at home, doing things like reading, knitting, etc. (Table 7; $\chi^2 = 20.56$, df = 4, $p < .01$).[10] She also goes out with her children less often, taking them skating, to a movie or out of Metro less often than more supported mothers (Table 8 (movies): $\chi^2 = 8.02$, df = 4, $p < .10$; (skating): $\chi^2 = 18.14$, df = 4, $p < .01$; (out of Metro): $\chi^2 = 14.78$, df = 4, $p < .05$).[11] It may just be that she does not have the time.

Consistent with this interpretation are the findings that those who are highly supported perceive more choice about what they do, engage in more leisure activities at home and go out with their children more. They have support and may well be freed up enough to do all of these things.

While this may be going on for some of the mothers it does not explain other findings so well. First of all, the fact that isolated mothers perceive that they have much too much to do does not explain all their tension. The other possibility suggested earlier was that isolation is stressful because it threatens a person's sense of self and worth. There are no data on self-esteem or self-concept in the time budget study. However, assuming that a person who does not feel secure in her sense of herself will tend to be less actively involved in things, that is, to be more withdrawn into herself, then there are data which are relevant. Given other findings that short periods of social isolation go with motivational losses (35) and that loneliness goes with lower self-esteem (30) and the tendency to avoid social situations that carry some risk (31,32), it does not seem unreasonable to consider the data to follow an indication of the effects of isolation. The data have primarily to do with the mother's involvement or lack of involvement with their children.

As reported earlier, their children go to movies, skating and out of Metro less often than other children and when they do go they are less likely to go with their parents. In addition to this, while isolated mothers have more time at home (they do not socialize or go out as much), they do not spend more time taking care of the children. In fact, among the women who have paid employment isolated mothers spend significantly less time taking care of their children (Table 9; $\chi^2 = 6.87$, df = 2, $p < .05$).[12] Part of this can be attributed to their having adolescents who require less care but not all. Other data suggest that something more complex than this is going on. Not only are they

not more involved in their children's care, the isolated mothers as a group less frequently report positive social exchanges with their children, things like talking to them, being affectionate with them or joking with them (Table 9; χ^2 = 8.34, df = 2, $p < .02$). This lack of positive involvement showed up again in the interviewers' observations of family interactions during the filling out of the time budget. Isolated mothers were significantly less often supportive and helpful despite a higher number of exchanges with their children (Table 9; χ^2 = 11.27, df = 6, $p < .05$).[13] Perhaps the strongest findings suggesting that isolated mothers are withdrawn into themselves comes from the time budget study question asking mothers to indicate who was with them during each of the activities they entered into their time budget for the day. Isolated mothers significantly more often fail to write their children in both when they say they are taking care of them and when they report positive social exchanges with them (Table 10; χ^2 = 10.93, df = 4, $p < .05$; χ^2 = 16.07, df = 4, $p < .01$). In another study on social isolation (15), two interviewers who talked with about 100 mothers had said that what distinguished the isolated mother was her tendency to be preoccupied with her own needs and to be much less aware of her children in terms of their needs and their individuality than the other mothers. We have yet to explore this in the other study but the data just reported here are consistent with these interviewers' observations. The isolated mother seems to be less positively involved with her children.[14]

An alternative explanation for these findings is that the "isolated" mother is isolated because of her own emotional difficulties. Her lack of involvement with her children and others would not be the result of isolation then but, rather, both the isolation and her lack of involvement with her children would be the result of this third factor. Data from questions discussing the mental state of the mothers do not support this interpretation. The isolated do not, as a group, differ from the more supported in terms of how often they feel on top of the world, lonely, excited, depressed, achieving, bored, proud, restless, like the world is going their way or criticized. What is true, however, is that the extremely isolated do report significantly more often feeling lonely, depressed and criticized and less often that the world is going their way (Table 11 (lonely): χ^2 = 15.92, df = 6, $p < .02$; (depressed): χ^2 = 15.75, df = 6, $p < .02$; (criticized): χ^2 = 4.05, df = 1, $p < .05$; (world going my way): χ^2 = 28.91, df = 6, $p < .01$). In addition, they express much more worry about areas of their life especially their

health and their marriage (Table 12; $\chi^2 = 17.49$, df = 9, $p < .05$).[15]

There are only ten extremely isolated mothers for whom mental state data are available. The number is small, but the pattern is highly significant. So while it is important to be cautious, these data do suggest that the measures were sensitive and that it is not depression and emotional difficulties which result in isolation and non-involvement with children, but rather that the state of being isolated has negative consequences. Interestingly, the differences between the extremely isolated women and the isolated women are, first, that the latter has the support of her spouse and, second, that they report less stress. It is possible that having a supportive spouse relieves stress and while it does not totally alleviate the negative consequences of social isolation, it can reduce some of the negative emotions like depression experienced by the individual herself.

SUMMARY OF FINDINGS IN PRELIMINARY ANALYSES

Being isolated from the help provided through social relationships is sufficiently prevalent to be a cause for concern given its possibile relationship to emotional and physical health problems. Its prevalence varies from geographic area to geographic area and is more common for single women and for women with adolescents than others, but otherwise shows no pattern in data from 535 Metropolitan Toronto mothers. It does not vary significantly with income, housing type, or work status.

In terms of its affects on mothers, mothers who lack support from their spouse and had little support outside their homes, that is, the extremely isolated, more often feel depressed, lonely and criticized and less often on top of the world and worry more about other aspects of their lives like their health and their marriages than other mothers. But, importantly, mothers who lack support outside the home whether or not they have the support of their spouse (the extremely isolated and the isolated) experience more tension day to day. Two things seem to be going on. First, they more often feel they have much too much to do and having less help in doing it, they see less choice about what they do do. Tension may well be the result. Second, they seem more withdrawn into themselves in that they do less with and for their children, have positive exchanges with them less

frequently and less often acknowledge their actual presence. As a group they are distinguished from other mothers by being more worried about their parenting.

This is a picture of the isolated mother as tense, not coping well with day to day responsibilities even to the point of being somewhat less positively involved with her children. While other work has suggested that in addition to affecting well-being isolation affects parenting (27), it is usually assumed to be the same group of people affected. What is significant here is that isolation may not only be disruptive to the parenting of those whose emotional state it affects, but also to others and a large group at that.

IMPLICATIONS FOR INTERVENTION

These findings have implications for how to go about reaching isolated mothers.

First, though the geographic units used were large, the data suggests that isolation varies from one area, and likely neighbourhood, to another. This suggests that neighbourhood-based interventions are important, particularly for mothers who are not working, in order to have a better chance of reaching a significant number of those who are isolated.

Second, to the extent that the tension and disruption in parenting are due to having too much to do, interventions which provide practical help and even relief from these responsibilities are suggested.

Third, to the extent that the tension and disruptions in parenting reflect an isolated mother's tendency to withdraw into herself, lacking the confidence for positive, active involvements outside the home with others and even inside the home with her children, then a qualitatively different kind of intervention is suggested. It is not sufficient to provide opportunities for these mothers to have help or to get relief from the responsibilities. For preventive interventions trying to reduce isolation to be effective in these cases, it is necessary to acknowledge and deal with the effects of isolation on a mother's self-esteem and motivational level. Sensitive outreach is needed in combination with opportunities to function in non-threatening social settings which provide not

only needed social relationships but support around parenting specifically and probably self-esteem in general.

One such intervention for mothers at home with preschoolers has been set up in a high risk area of Toronto. The idea is to provide informal neighbourhood settings where mothers can meet and spend time with others who are in similar circumstances. Staff do outreach and are there to provide support personally and also to help mothers get to know and become supports to one another. Beyond this, staff encourage the involvement of mothers in organizing and running this community organization and in this way help the mothers identify and build on their strengths and capabilities.

The process takes time. Mothers are at very different points when they first come out. Staff recognize this but still try, without pressuring, to provide a context in which every mother experiences another's (i.e. staff's) confidence in her ability and appreciation of her unique contribution. In this way they hope to provide an environment in which a mother can develop confidence in herself at her own pace.

The effectiveness of the Centre in reducing isolation, in supporting mothers' sense of their worth in general and as a parent, and in preventing dysfunction is currently being evaluated (15). This Centre is a good example of an intervention trying to be sensitive to the effects of social isolation. As we develop a better understanding of social isolation and how it affects people, whether it is to confirm, elaborate or supplant those offered here, hopefully other interventions equally sensitive will be put in place and evaluated.

TABLE 1

Extent of Social Isolation in Different Communities

Study	Community	Sample	Measure	Isolated % of Samples
Andrews et al 1977	Suburb of Sydney, Aust. Pop: 15,000 Majority live in low-density nuclear family dwellings 34% women work 80% had lived there 10 years or more	n = 863 Method: random sample of every 8th household: all adults asked to participate Respondents: men and women aged 20-69 Response rate: 90% Data collected: 1976-7	Crisis Support -no one to turn to for comfort in a crisis -no one to call on for material help in a crisis	4.9 8.3
Berkman & Syme 1979	Alameda County, Calif. Pop: 1,000,000 in '70 Near San Francisco - highly urbanized Diversity in SES and ethnicity	n = 4,725 Method: subsample of larger stratified sample which excluded institutionalized population Respondents: men and women aged 20-69 Response rate: 86% Data collected: 1965	Score of 1 on 4 level social network index. Sum of: 1. married or not 2. # of close friends and relatives and frequency of contact 3. church members 4. member other organization weighting 1st two move	9.2

TABLE 1 (cont'd) #2

Study	Community	Sample	Measure	Isolated % of Samples
Brown et al 1975	Amberwell: working class district in London Pop: 150,000	n = 220 Method: random sample of households, excluding the West Indian population Respondents: women aged 18-65 Response rate: 85% Data collected: 1973-4	Not having an intimate, confiding relationship with a boyfriend or spouse	
			overall	38.3
			married only	26.6
Michelson W. et al 1980	Metropolitan Toronto Pop: women with children (1976 Census): 366,135 Diversity in ethnicity, SES, housing, family life stage, urbanization	n = 542 Method: stratified random sampling in 20 randomly selected census tracts: households within selected block included if they had children Respondents: women with children, aged 20-50 Response rate: ? Data collected: 1980	Cannot turn to a spouse about personal problems	
			overall	26.9
			married only	8.4
			Cannot turn to spouse and have no one else to turn to for help and support	
			overall	2.5
			married only	1.4
			single (assuming 18% are single)	7.1
Wellman, B. 1979	East York, municipality: Toronto, Ont. Upper working class/ lower middle class predominantly British-Canadian inner suburb Pop: 18+: 85,100 (1976 Census) Community characterized by solidarity	n = 845 Method: random sample Respondents: men and women, 18+ Response rate: ? Data collected: 1968	Extreme isolation and isolation as used in the paper (see pp. 5-6)	12.5
			Not having persons outside your home you feel close to	2.0
			Help not available in emergency situations	19.0
			Help not available in dealing with day to day matters	40.0

TABLE 2

Social Contacts and Outings in a 24-Hour Period by Level of Isolation of Mother

LEVEL OF ISOLATION OF MOTHER	N	SOCIALIZING CONTACTS		OUTINGS		WHO WITH (SOCIALIZING)		WHO WITH (OUTINGS)	
		None	One or More	None	One or More	Alone	With Friends	Alone	With immediate family
Isolated	67	57	10	65	2	60	7	66	1
Moderately supported	415	274	141	365	50	298	117	398	17
Highly supported	53	36	17	41	12	38	15	46	7
Total	535	367	168	471	64	396	139	510	25
x^2 =		9.69		10.76		9.61		10.28	
df =		2		2		2		2	
p		<.01		<.01		<.01		<.01	

TABLE 3

Distribution of Social Isolation of Mothers by Geographic Area of Metropolitan Toronto

LEVEL OF ISOLATION OF MOTHERS	N	City West	City North	City South	City East	Old Suburb	New Suburb
Isolated	67	9	3	10	6	15	24
Moderately supported	415	45	28	25	38	90	189
Highly supported	53	4	8	1	6	7	27
Total	535	58	39	36	50	112	240

$x^2 = 18.75$

df = 10

$\varrho < .05$

TABLE 4

Distribution of Isolation of Mothers by Family Status Variables

LEVEL OF ISOLATION	N	MARITAL STATUS		N	FAMILIES WITH PRESCHOOLERS		FAMILIES WITH ADOLESCENTS	
		Single	Married		At least one preschooler	No pre-schoolers	At least one adolescent	No adol-escents
Extremely Isolated*	13	7	6	67	26	41	31	36
Isolated	43							
Moderately supported	414	92	418	415	225	190	113	302
Highly supported	53			53	32	21	14	39
Total	523	99	424	535	283	252	158	377
x^2 =		10.29			6.82		10.32	
df =		1			2		2	
p		$<.01$			$<.05$		$<.01$	

* Information as to support from husband is not reported for 11 of 67 of the isolated and marital status is not reported for one other mother. The χ^2, therefore, is based on an n of 523 in this case.

TABLE 5

Tension Associated with Daily Activities by Level of Isolation of Mother

LEVEL OF ISOLATION	N	$\bar{X}$ TENSION SCORE ASSOCIATED WITH DAILY ACTIVITIES*		
		Tense (1-3)	Neutral to Relaxed (4-7)	No response
Isolated	67	17	48	2
Moderately supported	415	38	368	9
Highly supported	53	6	47	0
Total	535	61	463	11

* $\bar{X}$ calculated from score assigned to each activity mother entered in 24-hour time budget; 1 = very tense, 7 = very relaxed

TABLE 6

Sense of Choice and Perceptions of Amount to Do by Level of Isolation of Mother

LEVEL OF ISOLATION	N	EVALUATION OF AMOUNT TO DO IN LAST WEEK					$\bar{X}$ SENSE OF CHOICES ASSOCIATED WITH DAILY ACTIVITIES*		
		Too Little	Right Amount	Too Much	Much too Much	No response	Low Choice	Some to Free Choice	No response
Isolated	67	4	24	28	9	2	41	24	2
Moderately supported	415	24	114	245	27	5	203	203	9
Highlu supported	53	0	13	37	3	0	21	32	0
Total	535	28	151	310	39	7	265	259	11
x^2 =				17.87				6.86	
df =				2				6	
Q =				$<.05$				$<.05$	

* $\bar{X}$ calculated from score assigned to each activity mother entered in 24-hour time budget; 1 = no choice, 4 = some choice, 7 = free choice.

TABLE 7

Non-Social Leisure Activities by Level of Isolation of Mother

LEVEL OF ISOLATION	N	NUMBER OF NON-SOCIAL LEISURE ACTIVITIES IN 24-HOUR PERIOD		
		None	1-6	7 or more
Isolated	67	11	48	13
Moderately supported	415	36	231	148
Highly supported	53	2	21	30
Total	535	49	296	191

x^2 = 20.56
df = 4
p < .01

TABLE 8

Children's Activities by Level of Isolation of Mother

Level of Isolation	N	MOVIE*				SKATING				OUT OF METRO			
		None	Without Parents	With Parents	No response	None	Without Parents	With Parents	No response	None	Without Parents	With Parents	No response
Isolated	67	28	22	16	1	33	21	10	2	29	7	31	0
Moderately supported	415	136	113	163	2	157	132	122	4	117	32	262	1
Highly supported	53	19	10	24	0	16	12	25	0	7	4	41	1
Total	535	183	145	203	3	206	165	157	6	153	43	334	2

x^2 =	8.02	18.14	14.78
df =	4	4	4
ρ =	$<.10$	$<.01$	$<.01$

* At least one child went in the last month.

TABLE 9

Frequency of Involvement with Children by Level of Isolation of Mother

LEVEL OF ISOLATION	N	INCIDENTS OF CHILDCARE IN 24 HOUR PERIOD*			N	NUMBER OF POSITIVE SOCIAL EXCHANGES IN 24 HOUR PERIOD			N	OBSERVED FREQUENCY OF TYPES OF MOTHER TO CHILD COMMUNICATIONS			
		0-1	2+	No response		0-4	5+	No response		Ask/correct	Order, angry	Help, support	No data for
Isolated	67	19	35	13	81	38	16	13	81	43	17	21	11
Moderately supported	415	102	304	9	407	243	163	9	407	172	81	154	2
Highly supported	53	7	46	0	32	23	30	0	32	20	1	11	0
Total	535	128	305	22	520	304	209	22	520	235	99	286	13
x^2 =		6.87				8.34				11.27			
df =		2				2				6			
ρ =		$<.05$				$<.02$				$<.05$			

* Accounted for totally by mothers with paid employment

TABLE 10

Mother's Recognition of Presence of Others by Level of Isolation of Mother

LEVEL OF ISOLATION	N	% CHILD CARE ACTIVITIES SAY WITH ANYONE FROM IMMEDIATE FAMILY			% POSITIVE SOCIAL EXCHANGES WITH CHILD SAY WITH ANYONE FROM IMMEDIATE FAMILY		
		None	up to 80%	80-100%	None	up to 80%	80-100%
Isolated	67	24	11	32	29	2	36
Moderately supported	415	98	55	262	127	40	248
Highly supported	53	7	11	35	7	9	37
Total	535	129	77	329	163	51	321
x^2 =			10.93			16.07	
df =			4			4	
ρ =			$<.05$			$<.01$	

TABLE 11

Mental State of Mothers by Level of Isolation*

LEVEL OF ISOLATION	N	LONELY				DEPRESSED				WORLD GOING MY WAY			
		Never	Sometimes	Often	No response	Never	Sometimes	Often	No response	Never	Sometimes	Often	No response
Extremely isolated	13	3	2	5	3	2	3	5	3	5	2	3	3
Isolated	43	15	18	4	6	10	23	5	6	4	22	11	6
Moderately supported	415	181	163	43	28	116	230	39	30	27	258	98	32
Highly supported	53	27	19	5	2	15	29	7	2	2	38	11	2
Total	523	226	202	57	39	143	285	56	41	38	320	123	43
x^2 =			15.92				15.75				28.91		
df =			6				6				6		
p =			$<.02$				$<.02$				$<.01$		

* Frequency of feeling criticized had the same pattern but was only marginally significant ($\chi^2 = 4.05$, df = 1, $p < .05$)

TABLE 12

$\bar{X}$ Level of Worry About Areas of Life by Level of Isolation of Mother*

LEVEL OF ISOLATION	N	NONE	A SMALL AMOUNT	A MODERATE AMOUNT	QUITE A BIT/ A GREAT DEAL	NO RESPONSE
Extremely isolated	13	1	2	7	3	0
Isolated	43	7	21	12	3	0
Moderately supported	415	86	206	90	32	1
Highly supported	53	10	27	8	8	0
Total	523	104	256	117	46	1

x^2 = 17.49

df = 9

ρ = $< .05$

* Concerns about ill health and their marriage contributed most strongly to this pattern, with concerns about education and employment similar but weaker. Concerns about finance were not significant. Concerns about parenting showed a different pattern with both groups of isolates indicating more worry than those who had suppporting. This latter finding mirrors the behavioural differences reported elsewhere in the paper.

FOOTNOTES

1. This paper was made possible by Canada Health and Welfare Grant No. 4555-21-14 to Dr. William Michelson and by a Hospital for Sick Children Foundation grant to the University of Toronto, establishing the Child in the City programme.

   I am grateful to Howard Andrews and Penny Lawler for their helpful reactions to an earlier draft of this paper and I am especially grateful to Philip Webb for his skill and reliability in computer programming.

2. Originally this paper was going to discuss the extent, type and consequences of social isolation in a sample of 200 mothers at home with their preschoolers and living in a relatively recently established community in Toronto. However, at some point, it became apparent that data available from another sample was a better choice for assessing the extent, distribution and implications of social isolation. This second sample contains 535 women and is composed of women who have paid employment and women who are at home, who are at various stages in raising their families, and who live in dramatically different communities in Metropolitan Toronto.

3. For a detailed review of the literature see Hodgson, 1981.

4. An evaluation of such an effort is now underway (15).

5. See Hodgson, 1981, for a discussion of social isolation in terms of its political viability.

6. It will be important to look at different kinds of isolation both from socializing contacts and from help important to coping and to refine this later category further by looking at isolation, from emergency help versus task help versus emotional support to see if individuals are affected differently. While this paper focused on isolation it will also be of interest to see if different sources of support to the moderately supported make a difference to the mothers. This will have implications for how to intervene.

7. Data will be analyzed by husband's occupation in the future which is more consistent with the Beckman and Syme analyses referred to earlier.

8. Mothers of preschoolers are still not more isolated when a measure of isolation more comparable to Brown et al is used in the analysis.

9. Studying isolation was not central to the time budget study from which these data in Metropolitan Toronto are drawn and therefore it did not have a suitable sampling strategy.

10. Watching television was analyzed separately and there were no significant differences.

11. This is not due to the fact that isolated mothers more often have adolescents in the sample.

FOOTNOTES (continued)

12. It will be important to supplement these analyses of the frequencies of different kinds of activities with a look at the actual amount of time spent in these activities to be sure of this interpretation.

13. The fact that isolated mothers interacted significantly more with their children than others contradicts the image of them as withdrawn. Further analyses of this finding are planned to clarify its meaning. It may be that a task with an observer present alters their interaction level.

14. They do not rate their children more negatively on things like independence, humour and achievement.

15. Interestingly, the one area where the two categories of isolates have similar levels of worry is around their parenting. This is consistent with the behavioural data already discussed which shows that the parenting of both these groups seems to be affected by isolation.

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